PRINTED: 05/18/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBI		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVS3543AGZ				B. WING		C 02/28/2011		
NAME OF PR	OVIDER OR SUPPLIER	NVOOOTOAGE	STREET ADD	I RESS, CITY, STA	ATE, ZIP CODE	02/20	0/2011	
COTTAGES OF GREEN VALLEY				E ROBINDALE ROAD ERSON, NV 89074				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE		
Y 000	Initial Comments			Y 000				
	by the Health Division prohibiting any criminactions or other claim available to any party state, or local laws. This Statement of Deta result of a complain your facility 2/17/11 the Licensure survey was of NRS 449.150, Pow The facility is licensed for Group beds which disabled and 67 beds Alzheimer's category	36 was substantiated.	I as is, ral, ed as ed on tate hority fon. acility or th					
Y 740 SS=D	10 449.272(1)(a)-(c) Indwelling Catheter			Y 740				
	catheter must not be a facility or be permitted a residential facility ur (a) The resident is phycapable of caring for a with or without the assemble (b) Irrigation of the catheter accordance with the permedical professional provide that care. (c) The catheter is instantial accordance with the permedical professional provide that care.	ysically and mentally all aspects of the condi sistance of a caregiver.	al nt of tion, o					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 05/18/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING B. WING	<u></u>	С		
NVS3543AGZ						02/28/2	2011	
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA				
COTTAGE	S OF GREEN VALLEY		2620 E ROBINDALE ROAD HENDERSON, NV 89074					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
Y 740	Continued From page	Continued From page 1						
	medical professional insert and remove a c	who has been trained t catheter.	o					
	This Regulation is not met as evidenced by: Based on interview on 2/17/11, the facility admitted and retained a resident who was not physically and mentally capable of caring for all aspects of an indwelling catheter (Resident #1). Severity: 2 Scope: 1		ot · all					
	WAIVERS		Y 830					
SS=D	submit to the Division permission to admit o prohibited from being facility or remaining a	of a residential facility of a written request for or retain a resident who admitted to a residentis a resident of the facil .271 to 449.2734, incl	is al ity					
	Based on interview of	ot met as evidenced by: n 2/17/11, the facility fa n was requested to adr	iled					

PRINTED: 05/18/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		NIV. 025 42 A C 7		A. BUILDING B. WING		C 02/28/2011			
NAME OF DE	ACVIDED OD CURRUED	NVS3543AGZ	STDEET ADDI	DESS CITY STA	ATE ZIP CODE	02/28	5/2011		
NAME OF PR	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE					
COTTAGE	COTTAGES OF GREEN VALLEY 2620 E ROBINDALE ROAD HENDERSON, NV 89074								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE COMPLETE THE APPROPRIATE DATE			
Y 830	Continued From page 2			Y 830					
	and retain a resident with a Foley catheter (Resident #1).								
	Severity: 2 Scope:	1							

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.